



Welcome!

PATIENT NAME: _____ DATE OF BIRTH _____

AGE _____

ADDRESS _____

HOME PHONE _____ CELL PHONE _____ WORK PHONE _____

SS# _____ *Email for Appointment Confirmation _____

EMPLOYER _____ OCCUPATION _____

SPOUSE NAME _____ SPOUSE CELL PHONE _____

SPOUSE EMPLOYER _____ SPOUSE OCCUPATION _____

DENTIST NAME _____ DATE OF LAST DENTAL EXAM _____

PHYSICIAN NAME _____ ARE YOU IN GOOD HEALTH? Yes No

IF NO, PLEASE EXPLAIN _____

LIST ANY ALLERGIES OR DRUG SENSITIVITY Penicillin _____ Codeine _____ OTHER _____

PLEASE LET OUR OFFICE KNOW IF YOU ARE TAKING ANY OF THE FOLLOWING MEDICATIONS ON A REGULAR/PROLONGED PERIOD OF TIME AS THEY INHIBIT OR SLOW DOWN TOOTH MOVEMENT:

Vioxx How long? _____ Dosage? _____ mg

Celebrex How long? _____ Dosage? _____ mg

Aspirin How long? _____ Dosage? _____ mg

Ibuprofen How long? _____ Dosage? _____ mg

Fosamax How long? _____ Dosage? _____ mg

Actonel How long? _____ Dosage? _____ mg

Please list below any other medications or supplements and dosage you are currently taking:

_____	_____
_____	_____
_____	_____

Any accidents causing injury to Face, Mouth or Teeth? _____

When? _____

CHECK THE FOLLOWING FOR WHICH PATIENT HAS BEEN TREATED:

- Glaucoma Rheumatic Fever Prolonged Bleeding Tuberculosis
- Diabetes Herpes Kidney Involvement Endocrine Problems (Hormones)
- Hepatitis Bone Disorders Fainting
- Asthma Heart Trouble/Chest Pain Epilepsy/Convulsions

DO YOU NEED TO BE PRE-MEDICATED PRIOR TO ANY DENTAL PROCEDURES? Yes No

Reason for Pre-Medication_____

ARE YOU PREGNANT? Yes No DO YOU WEAR CONTACT LENSES? Yes No

LIST ANY SERIOUS HEALTH PROBLEMS_____

Did you ever suck thumb or fingers as a child? Yes No If Yes, until what age?_____

Are you a Mouth Breather?..... While Awake? Yes No While Asleep? Yes No

Have you been informed of any missing or extra teeth? Yes No

Has an Orthodontist or Periodontist (Gum Specialist) been consulted previously? Yes No

Other members of your family who have had Orthodontic Treatment:

Referred to this office by:_____

Reason for Consultation:_____

Signature_____ Date_____